HEALTH RECORD COVER

Last Name First Middle

0 1 2 3 4 5 6 7 8 9

Place Sensitivity Sticker Here (if needed)

Blood Type Rh

Special Status
□ Aviation
□ OMMP
□ Waiver
□_____

YY MM DD
Date of Birth

U.S. Coast Guard

HEALTH RECORD

PRIVACY STATEMENT; HEALTH CARE RECORDS

1. AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN): Section 632 of Title14, United States Code and Section 1071-1087, Title 10 United States Code, Executive Order 9397.
2. PRINCIPLE PURPOSE FOR WHICH INFORMATION IS TO BE USED:
The purpose for requesting personal information is to assist health care personnel in developing records to facilitate and document your health in order to provide health care and to provide a complete account of such care rendered including diagnosis, treatment, and end result. The SSN is necessary to identify the person and records.
3. ROUTINE USES; This information may be used to plan and coordinate health care. It may be used to provide health care, conduct research, teach, complile statistical data, determine suitability of persons for service or assignment, implement, preventive health and communicative disease control programs, adjudicate claims and determine benefits, evalutate care rendered, determine professional certification and hospital accreditation, conduct authorized investigations, provide physical qualifications of patients to other Federal, State, and local agencies uopn request in the pursuit of their official duties, and report health conditions required by law to Federal, State, and local agencies. It may be used for other lawful purposes, including law enforcement and litigation.
4. The above Privacy Act Statement applies to all requests for personal information made by health care personnel or for health care purposes. Failure to provide the requested information for these health records may result in an inability of Coast Guard health care personnel to afford treatment.
5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the commanding officer for decision.

DEPT. OF TRANSP, USCG, CG-3443 (REV 9-92) **SN 7530-00-F01-4180**
PREVIOUS EDITIONS ARE OBSOLETE

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET

(This form is subject to the Privacy Act of 1974 – Use DD form 2005)

1. ALLERGIES

a. MEDICATION ALLERGIES	b. OTHER ALLERGIES

2. CHRONIC ILLNESS	**3. MEDICATIONS**

4. HOSPITALIZATIONS/SURGERIES

5. COUNSELING

F	FITNESS	a. DATE					
D	DENTAL	b. AGE					
I	INJURY PREVENTION	c. TOPIC					
N	NUTRITION/FOLATE						
C	CANCER PREVENTION						
S	SAFE SEX	d. DATE					
FP	FAMILY PLANNING	e. AGE					
Rx	PRESENT MEDICATIONS	f. TOPIC					
MH	MENTAL HEALTH/STRESS/SUICIDE/ OCCUPATIONAL STRESS						
H	HORMONE/CALCIUM REPLACEMENT	g. DATE					
To	TOBACCO	h. AGE					
A	ALCOHOL/SUBSTANCE ABUSE	i. TOPIC					
t	TRAVEL						
O.	OCCUPATIONAL EXPOSURE (HEARING THRESHOLD CHANGES/CUMULATIVE TRAUMA DISORDER)						
		j. DATE					
		k. AGE					
		i. TOPIC					

ADVANCE DIRECTIVES: DATE FILED

PATIENT'S IDENTIFICATION (Use this space for mechanical imprint)

SUPPLIED (Navy)
2766-0102-LF-984-8400, pkg-100

RECORDS MAINTAINED AT:

PATIENT'S NAME LAST	FIRST	M.I.	**SEX**

RELATIONSHIP TO SPONSOR	**STATUS**	**RANK/GRADE**

SPONSOR'S NAME *(Last ,First, Middle Initial)*	DEPT/SERVICE

ORGANIZATION	**SSN/ID NUMBER**	**DATE OF BIRTH**

DD FORM 2766, (Rev 01- 00) **PAGE 1 of 4 PAGES**

ADULT PREVENTION AND CHRONIC CARE FLOWSHEET

6. FAMILY HISTORY *(M = Mother, F = Father, S = Sibling, MGM = Maternal Grandmother, MGF = Maternal grandfather, PGM = Paternal Grandmother, PGF = Paternal Grandfater)*

a. CANCER *(Specify)*	
b. CARDIOVASCULAR DISEASE *(Specify)*	
c. DIABETES *(Specify)*	
d. MENTAL ILLNESS/CHEMICAL DEPENDENCY *(Specify)*	

7. SCREENING EXAMS *(* = Actual Result, * * = Tricare Benefit, N = Normal, X = Abnormal, E = Done Elsewhere, R = Refused NA = Not Indicated) (● = Next Due)*

a. TEST	b. FREQUENCY	c. YEAR / d. AGE						
			e. DATES					
(1) CLINICAL DISEASE PREV EVAL/PHA (HEAR)	ANNUAL		O	O	O	O	O	O
* (2) WEIGHT	ANNUAL FOR ACTIVE DUTY		O	O	O	O	O	O
* (3) HEIGHT	ANNUAL FOR ACTIVE DUTY		O	O	O	O	O	O
* (4) BLOOD PRESSURE	ONCE q 2 YRS for BP< 130/85, ANNUAL IF GREATER		O	O	O	O	O	O
* (5) CHOLESTEROL**	*q 5 YRS FOR AGE ≥ 18 q YR if PREV ABN		O	O	O	O	O	O
(6) HEARING	CLINICAL DISCRETION		O	O	O	O	O	O
(7) SKIN EXAM *(Cancer)*	ANNUAL IF AT RISK		O	O	O	O	O	O
(8) ORAL/DENTAL **	ANNUAL		O	O	O	O	O	O
(9) EYE/VISION **	ROUTINE ACUITY WITH PERIODIC ASSESSMENT DIABETES ANNUAL GLAUCOMA CHECK: Blacks q 3-5 yrs age 20-39 All q 2-4 years age 40-64				O	O	O	O
(10) BREAST EXAM	ANNUAL: ≥ 40 YRS		O	O	O	O	O	O
(11) MAMMOGRAM **	BASELINE@ 40, q 2 YRS 40-50, ANNUALLY > 50		O	O	O	O	O	O
(12) PAP ** (*Digital Rectal Exam*)	BASELINE: AGE 18 OR ONSET OF SEXUAL ACTIVITY AFTER 3 NL ANUUAL EXAMS, PERFORM q 1-3 years		O	O	O	O	O	O
(13) FECAL OCCULT BLOOD	ANNUAL ≥ 50 yrs		O	O	O	O	O	O
(14) SIGMOID	EVERY 3-5 YRS: ≥ 50 YRS		O	O	O	O	O	O
(15) COLONOSCOPY	HIGH RISK q 5 YRS ≥ YRS		O	O	O	O	O	O
(16) TESTICULAR	HIGH RISK ANNUAL 13-39 YRS		O	O	O	O	O	O
(17) PROSTATE ** **(DIGITAL RECTAL EXAM*)	WITH P.E. ≥ 40 YRS *(Presently Recommended annually)*		O	O	O	O	O	O
(18) RUBELLA SCREEN *(Females)*	ONCE BETWEEN AGES 12 –18 YRS *(Unless prev vaccinated)*		O	O	O	O	O	O
(19) OCCUPATIONAL SCREENING EXAMS	APPROPRIATE TO EXPOSURES		O	O	O	O	O	O
(20)			O	O	O	O	O	O
(21)			O	O	O	O	O	O
(22)			O	O	O	O	O	O

ADULT PREVENTION AND CHRONIC CARE FLOWSHEET

8. OCCUPATIONAL HISTORY/RISK

a. PRP		YES		NO
b. .FLYING STATUS		YES		NO

9. IMMUNIZATIONS *(Enter numeric class in sub block)*

(1) IMMUNIZATION	(2) DATE *(ddmmmyyyy)*	(1) IMMUNIZATION	(2) DATE *(DDMMMYYYY)*	(1) IMMUNIZATION	(2) DATE *(ddmmmyyyy)*	(1) IMMUNIZATION	(2) DATE *(ddmmmyyyy)*
a. HEP A # 1		f. MMR # 1		j. TD *(q 10 YRS) (Last)*			
b. HEP A # 2		g. MMR #2		k. TD *(DUE)*			
c. HEP B # 1		h. PNEUMOCOCCUS		l. YELLOW FEVER *(LAST)*			
d. HEP B #2		i. POLIO OPV = O IPV = I		m. YELLOW FEVER			

n. TYPHOID *(Enter numeric class in sub block) ORAL = O TYPHUM Vi = 1. TYPHOID USP = 2*	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

O. ANTHRAX	(1) INITIAL DATE	(2) 2 WEEK DATE	(3) 4 WEEK DATE	(4) 6 MONTH DATE	(5) 12 MONTH DATE	(6) 18 MONTHDATE

p. PPD *(Enter mm and date)*	(1) (a) mm	(2) (a) mm	(3) (a) mm	(4) (a) mm	(5) (a) mm	(6) (a) mm	(7) (a) mm
	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE	(b) DATE
q. INFLUENZA	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE	(7) DATE
r. VARICELLA	(1) DATE	(2) DATE	u. JAPANESE B ENCEPHALITIS	(1) DATE	(2) DATE	(3) DATE	(4) DATE
s. MENINGO	(1) DATE	(2) DATE	v. OTHER *(Specify)*	(1) DATE	(2) DATE	(3) DATE	
t. ADENO	(1) DATE	(2) DATE	w. OTHER *(Specify)*	(1) DATE	(2) DATE	(3) DATE	

10. READINESS *(Glucose-6-phosphate dehydrogenase)*

a. DNA	DATE:	b. BLOOD TYPE	DATE:	RESULT:	c. G-PD	DATE	RESULT:	d. SICKLE CELL	DATE:	RESULT:

e. PERMANENT PROFILE CHANGE	(1) DATE	(2) P:	(3) U:	(4) L:	(5) H:	(6) E:	(7) S:

f. GLASSES/GAS/MASK Rx:	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

g. DENTAL EXAM *(Enter numeric class in sub block)*	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

h. HIV TESTING	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

l. FITNESS *(In sub block enter P = Pass, F = Fail, W = Waiver)*	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE
	(1) DATE	(2) DATE	(3) DATE	(4) DATE	(5) DATE	(6) DATE

11. PRE/POST DEPLOYMENT HISTORY

a. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
b. LOCATION						
(1) PREDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	(d) DATE	(e) DATE	(f) DATE
(2) POSTDEPLOYMENT	(a) DATE	(b) DATE	(c) DATE	d) DATE	(e) DATE	(f) DATE
c. CHART AUDIT	○	○	○	○	○	○

ADULT PREVENTIVE AND CHRONIC CARE FLOWSHEET
(Continuation Sheet)

TEST	FREQUENCY	DATES					
		(a)	(b)	(c)	(d)	(e)	(f)

REMARKS

	RECORDS MAINTAINED AT:
	PATIENT'S NAME LAST / FIRST / M.I. — **SEX**
	RELATIONSHIP TO SPONSOR — **STATUS** — **RANK/GRADE**
	SPONSOR'S NAME *(Last, First, Middle Initial)* — **DEPT/SERVICE**
	ORGANIZATION — **SSN/ID NUMBER** — **DATE OF BIRTH**

DD FORM 2766, (Rev-01-00) **PAGE 4 OF 4 PAGES**

PREVIOUS EDITION IS USABLE AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION (*sign each entry)*

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART/SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(FOR TYPED OR WRITTEN ENTRIES, GIVE: name-last, first, middle ID NO or SSN; Sex; Date of Birth; Rank/Grade.);*	REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (Rev. 6-97)
Prescribed by GSA/ICMR
FIRMR 941 CFR) 201-9.202-1

BACK

REPORT OF MEDICAL EXAMINATION

1. DATE OF EXAMINATION (YYYYMMDD)	2. SOCIAL SECURITY NUMBER

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

3. LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	4. HOME ADDRESS (Street, Apartment Number, City, State and ZIP Code)	5. HOME TELEPHONE NUMBER (Include Area Code)

6. GRADE	7. DATE OF BIRTH (YYYYMMDD)	8. AGE	9. SEX	10. RACE	
			☐ Female ☐ Male	☐ American Indian/Alaskan Native ☐ Black	☐ Asian/Pacific Islander ☐ White

11. TOTAL YEARS GOVERNMENT SERVICE		12. AGENCY (Non-Service Members Only)	13. ORGANIZATION UNIT AND UIC/CODE
a. MILITARY	b. CIVILIAN		

14.a. RATING OR SPECIALTY (Aviators Only)	b. TOTAL FLYING TIME	c. LAST SIX MONTHS

15.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION	16. NAME OF EXAMINING LOCATION, AND ADDRESS (Include ZIP Code)
☐ Army ☐ Coast Guard ☐ Navy ☐ Marine Corps ☐ Air Force	☐ Active Duty ☐ Reserve ☐ National Guard	☐ Enlistment ☐ Medical Board ☐ Other ☐ Commission ☐ Retirement ☐ Retention ☐ U.S. Service Academy ☐ Separation ☐ ROTC Scholarship Program	

CLINICAL EVALUATION *(Check each item in appropriate column. Enter "NE" if not evaluated.)*

	Normal	Abnorm	NE
17. Head, face, neck, and scalp			
18. Nose			
19. Sinuses			
20. Mouth and throat			
21. Ears - General *(Int. and ext. canals/Auditory acuity under item 71)*			
22. Drums *(Perforation)*			
23. Eyes - General *(Visual acuity and refraction under items 61 - 63)*			
24. Ophthalmoscopic			
25. Pupils *(Equality and reaction)*			
26. Ocular motility *(Associated parallel movements, nystagmus)*			
27. Heart *(Thrust, size, rhythm, sounds)*			
28. Lungs and chest *(Include breasts)*			
29. Vascular system *(Varicosities, etc.)*			
30. Anus and rectum *(Hemorrhoids, Fistulae) (Prostate if indicated)*			
31. Abdomen and viscera *(Include hernia)*			
32. External genitalia *(Genitourinary)*			
33. Upper extremities			
34. Lower extremities *(Except feet)*			
35. Feet *(See Item 35 Continued)*			
36. Spine, other musculoskeletal			
37. Identifying body marks, scars, tattoos			
38. Skin, lymphatics			
39. Neurologic			
40. Psychiatric *(Specify any personality deviation)*			
41. Pelvic *(Females only)*			
42. Endocrine			

44. NOTES: *(Describe every abnormality in detail. Enter pertinent item number before each comment. Continue in item 73 and use additional sheets if necessary.)*

43. DENTAL DEFECTS AND DISEASE *(Please explain. Use dental form if completed by dentist. If dental examination not done by dental officer, explain in Item 44.)*

☐ Acceptable
☐ Not Acceptable Class _____

35. FEET *(Continued) (Circle category)*

Normal Arch	Mild	Asymptomatic
Pes Cavus	Moderate	
Pes Planus	Severe	Symptomatic

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

LABORATORY FINDINGS

45. URINALYSIS	a. Albumin	46. URINE HCG	47. H/H	48. BLOOD TYPE
	b. Sugar			

TESTS	RESULTS	HIV SPECIMEN ID LABEL	DRUG TEST SPECIMEN ID LABEL
49. HIV			
50. DRUGS			
51. ALCOHOL			
52. OTHER			
a. PAP SMEAR			
b.			
c.			

MEASUREMENTS AND OTHER FINDINGS

53. HEIGHT	54. WEIGHT	55. MIN WGT - MAX WGT	MAX BF %	56. TEMPERATURE	57. PULSE
	lbs.				

58. BLOOD PRESSURE			59. RED/GREEN *(Army Only)*	60. OTHER VISION TEST
a. 1ST	b. 2ND	c. 3RD		
SYS.	SYS.	SYS.		
DIAS.	DIAS.	DIAS.		

61. DISTANT VISION	62. REFRACTION BY AUTOREFRACTION OR MANIFEST	63. NEAR VISION
Right 20/ Corr. to 20/	By S. CX	Right 20/ Corr. to 20/ by
Left 20/ Corr. to 20/	By S. CX	Left 20/ Corr. to 20/ by

64. HETEROPHORIA *(Specify distance)*

ES ° EX ° R.H. L.H. Prism div. Prism Conv CT NPR PD

65. ACCOMMODATION		66. COLOR VISION *(Test used and result)*	67. DEPTH PERCEPTION *(Test used and score)* AFVT	
Right	Left	PIP /14	Uncorrected	Corrected

68. FIELD OF VISION	69. NIGHT VISION *(Test used and score)*	70. INTRAOCULAR TENSION	
		O.D.	O.S.

71a. AUDIOMETER	Unit Serial Number						71b. Unit Serial Number							72a. READING ALOUD TEST
Date Calibrated *(YYYYMMDD)*							Date Calibrated *(YYYYMMDD)*							☐ SAT ☐ UNSAT
HZ	500	1000	2000	3000	4000	6000	HZ	500	1000	2000	3000	4000	6000	
Right							Right							72b. VALSALVA
Left							Left							☐ SAT ☐ UNSAT

73. NOTES *(Continued)* **AND SIGNIFICANT OR INTERVAL HISTORY** *(Use additional sheets if necessary.)*

LAST NAME - FIRST NAME - MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

74.a. EXAMINEE/APPLICANT *(check one)*

- ☐ IS QUALIFIED FOR SERVICE
- ☐ IS NOT QUALIFIED FOR SERVICE

75. I have been advised of my disqualifying condition.

a. SIGNATURE OF EXAMINEE	b. DATE *(YYYYMMDD)*

b. PHYSICAL PROFILE

P	U	L	H	E	S	X	PROFILER INITIALS	DATE *(YYYYMMDD)*

76. SIGNIFICANT OR DISQUALIFYING DEFECTS

ITEM NO.	MEDICAL CONDITION/DIAGNOSIS	ICD CODE	PROFILE SERIAL	RBJ DATE *(YYYYMMDD)*	QUALI-FIED	DIS-QUALI-FIED	EXAMINER INITIALS	WAIVER RECEIVED	
								SERVICE	DATE *(YYYYMMDD)*

77. SUMMARY OF DEFECTS AND DIAGNOSES *(List diagnoses with item numbers) (Use additional sheets if necessary.)*

78. RECOMMENDATIONS - FURTHER SPECIALIST EXAMINATIONS INDICATED *(Specify) (Use additional sheets if necessary.)*

79. MEPS WORKLOAD *(For MEPS use only)*

WKID	ST	DATE *(YYYYMMDD)*	INITIAL	WKID	ST	DATE *(YYYYMMDD)*	INITIAL

80. MEDICAL INSPECTION DATE	HT	WT	%BF	MAX WT	HCG	QUAL	DISQ	PHYSICIAN'S SIGNATURE

81.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

82.a. TYPED OR PRINTED NAME OF PHYSICIAN OR EXAMINER	b. SIGNATURE

83.a. TYPED OR PRINTED NAME OF DENTIST OR PHYSICIAN *(Indicate which)*	b. SIGNATURE

84.a. TYPED OR PRINTED NAME OF REVIEWING OFFICER/APPROVING AUTHORITY	b. SIGNATURE

85. This examination has been administratively reviewed for completeness and accuracy.

a. SIGNATURE	b. GRADE	c. DATE *(YYYYMMDD)*

86. WAIVER GRANTED *(If yes, date and by whom)*

- ☐ **YES**
- ☐ **NO**

87. NUMBER OF ATTACHED SHEETS

BACK

REPORT OF MEDICAL HISTORY

(This information is for official and medically confidential use only and will not be released to unauthorized persons.)

Form Approved
OMB No. 0704-0413
Expires Aug 31, 2003

PLEASE DO NOT RETURN YOUR FORM TO THE ABOVE ADDRESS. RETURN COMPLETED FORM AS INDICATED ON PAGE 2.

PRIVACY ACT STATEMENT

AUTHORITY: 10 USC 504, 505, 507, 532, 978, 1201, 1202, and 4346; and E.O. 9397.
PRINCIPAL PURPOSE(S): To obtain medical data for determination of medical fitness for enlistment, induction, appointment and retention for applicants and members of the Armed Forces. The information will also be used for medical boards and separation of Service members from the Armed Forces.
ROUTINE USE(S): None.
DISCLOSURE: Voluntary; however, failure by an applicant to provide the information may result in delay or possible rejection of the individual's application to enter the Armed Forces. For an Armed Forces member, failure to provide the information may result in the individual being placed in a non-deployable status.

WARNING: The information you have given constitutes an official statement. Federal law provides severe penalties (up to 5 years confinement or a $10,000 fine or both), to anyone making a false statement. If you are selected for enlistment, commission, or entrance into a commissioning program based on a false statement, you can be tried by military courts-martial or meet an administrative board for discharge and could receive a less than honorable discharge that would affect your future.

1. LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	2. SOCIAL SECURITY NUMBER	3. TODAY'S DATE *(YYYYMMDD)*

4.a. HOME ADDRESS *(Street, Apartment No., City, State, and ZIP Code)*	5. EXAMINING LOCATION AND ADDRESS *(Include ZIP Code)*
b. HOME TELEPHONE *(Include Area Code)*	

X ALL APPLICABLE BOXES:

6.a. SERVICE	b. COMPONENT	c. PURPOSE OF EXAMINATION
☐ Army ☐ Coast Guard	☐ Active Duty	☐ Enlistment ☐ Medical Board ☐ Other *(Specify)*
☐ Navy	☐ Reserve	☐ Commission ☐ Retirement
☐ Marine Corps	☐ National Guard	☐ Retention ☐ U.S. Service Academy
☐ Air Force		☐ Separation ☐ ROTC Scholarship Program

7.a. POSITION *(Title, Grade, Component)*

b. USUAL OCCUPATION

8. CURRENT MEDICATIONS *(Prescription and Over-the-counter)*	9. ALLERGIES *(Including insect bites/stings, foods, medicine or other substance)*

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 on Page 2.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
10.a. Tuberculosis	○	○
b. Lived with someone who had tuberculosis	○	○
c. Coughed up blood	○	○
d. Asthma or any breathing problems related to exercise, weather, pollens, etc.	○	○
e. Shortness of breath	○	○
f. Bronchitis	○	○
g. Wheezing or problems with wheezing	○	○
h. Been prescribed or used an inhaler	○	○
i. A chronic cough or cough at night	○	○
j. Sinusitis	○	○
k. Hay fever	○	○
l. Chronic or frequent colds	○	○
11.a. Severe tooth or gum trouble	○	○
b. Thyroid trouble or goiter	○	○
c. Eye disorder or trouble	○	○
d. Ear, nose, or throat trouble	○	○
e. Loss of vision in either eye	○	○
f. Worn contact lenses or glasses	○	○
g. A hearing loss or wear a hearing aid	○	○
h. Surgery to correct vision *(RK, PRK, LASIK, etc.)*	○	○
12.a. Painful shoulder, elbow or wrist *(e.g. pain, dislocation, etc.)*	○	○
b. Arthritis, rheumatism, or bursitis	○	○
c. Recurrent back pain or any back problem	○	○
d. Numbness or tingling	○	○
e. Loss of finger or toe	○	○

12. *(Continued)*	YES	NO
f. Foot trouble *(e.g., pain, corns, bunions, etc.)*	○	○
g. Impaired use of arms, legs, hands, or feet	○	○
h. Swollen or painful joint(s)	○	○
i. Knee trouble *(e.g., locking, giving out, pain or ligament injury, etc.)*	○	○
j. Any knee or foot surgery including arthroscopy or the use of a scope to any bone or joint	○	○
k. Any need to use corrective devices such as prosthetic devices, knee brace(s), back support(s), lifts or orthotics, etc.	○	○
l. Bone, joint, or other deformity	○	○
m. Plate(s), screw(s), rod(s) or pin(s) in any bone	○	○
n. Broken bone(s) *(cracked or fractured)*	○	○
13.a. Frequent indigestion or heartburn	○	○
b. Stomach, liver, intestinal trouble, or ulcer	○	○
c. Gall bladder trouble or gallstones	○	○
d. Jaundice or hepatitis *(liver disease)*	○	○
e. Rupture/hernia	○	○
f. Rectal disease, hemorrhoids or blood from the rectum	○	○
g. Skin diseases *(e.g. acne, eczema, psoriasis, etc.)*	○	○
h. Frequent or painful urination	○	○
i. High or low blood sugar	○	○
j. Kidney stone or blood in urine	○	○
k. Sugar or protein in urine	○	○
l. Sexually transmitted disease *(syphilis, gonorrhea, chlamydia, genital warts, herpes, etc.)*	○	○
14.a. Adverse reaction to serum, food, insect stings or medicine	○	○
b. Recent unexplained gain or loss of weight	○	○
c. Currently in good health *(If no, explain in Item 29 on Page 2.)*	○	○
d. Tumor, growth, cyst, or cancer	○	○

Reset

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

Mark each item "YES" or "NO". Every item marked "YES" must be fully explained in Item 29 below.

HAVE YOU EVER HAD OR DO YOU NOW HAVE:	YES	NO
15.a. Dizziness or fainting spells	○	○
b. Frequent or severe headache	○	○
c. A head injury, memory loss or amnesia	○	○
d. Paralysis	○	○
e. Seizures, convulsions, epilepsy or fits	○	○
f. Car, train, sea, or air sickness	○	○
g. A period of unconsciousness or concussion	○	○
h. Meningitis, encephalitis, or other neurological problems	○	○
16.a. Rheumatic fever	○	○
b. Prolonged bleeding *(as after an injury or tooth extraction, etc.)*	○	○
c. Pain or pressure in the chest	○	○
d. Palpitation, pounding heart or abnormal heartbeat	○	○
e. Heart trouble or murmur	○	○
f. High or low blood pressure	○	○
17.a. Nervous trouble of any sort *(anxiety or panic attacks)*	○	○
b. Habitual stammering or stuttering	○	○
c. Loss of memory or amnesia, or neurological symptoms	○	○
d. Frequent trouble sleeping	○	○
e. Received counseling of any type	○	○
f. Depression or excessive worry	○	○
g. Been evaluated or treated for a mental condition	○	○
h. Attempted suicide	○	○
i. Used illegal drugs or abused prescription drugs	○	○
18. FEMALES ONLY. Have you ever had or do you now have:		
a. Treatment for a gynecological (female) disorder	○	○
b. A change of menstrual pattern	○	○
c. Any abnormal PAP smears	○	○
d. First day of last menstrual period *(YYYYMMDD)*		
e. Date of last PAP smear *(YYYYMMDD)*		

	YES	NO
19. Have you been refused employment or been unable to hold a job or stay in school because of:		
a. Sensitivity to chemicals, dust, sunlight, etc.	○	○
b. Inability to perform certain motions	○	○
c. Inability to stand, sit, kneel, lie down, etc.	○	○
d. Other medical reasons *(If yes, give reasons.)*	○	○
20. Have you ever been treated in an Emergency Room? *(If yes, for what?)*	○	○
21. Have you ever been a patient in any type of hospital? *(If yes, specify when, where, why, and name of doctor and complete address of hospital.)*	○	○
22. Have you ever had, or have you been advised to have any operations or surgery? *(If yes, describe and give age at which occurred.)*	○	○
23. Have you ever had any illness or injury other than those already noted? *(If yes, specify when, where, and give details.)*	○	○
24. Have you consulted or been treated by clinics, physicians, healers, or other practitioners within the past 5 years for other than minor illnesses? *(If yes, give complete address of doctor, hospital, clinic, and details.)*	○	○
25. Have you ever been rejected for military service for any reason? *(If yes, give date and reason for rejection.)*	○	○
26. Have you ever been discharged from military service for any reason? *(If yes, give date, reason, and type of discharge; whether honorable, other than honorable, for unfitness or unsuitability.)*	○	○
27. Have you ever received, is there pending, or have you ever applied for pension or compensation for any disability or injury? *(If yes, specify what kind, granted by whom, and what amount, when, why.)*	○	○
28. Have you ever been denied life insurance?	○	○

29. EXPLANATION OF "YES" ANSWER(S) *(Describe answer(s), give date(s) of problem, name of doctor(s) and/or hospital(s), treatment given and current medical status.)*

NOTE: HAND TO THE DOCTOR OR NURSE, OR IF MAILED MARK ENVELOPE "TO BE OPENED BY MEDICAL PERSONNEL ONLY."

LAST NAME, FIRST NAME, MIDDLE NAME (SUFFIX)	SOCIAL SECURITY NUMBER

30. EXAMINER'S SUMMARY AND ELABORATION OF ALL PERTINENT DATA *(Physician/practitioner shall comment on all positive answers in questions 10 - 29. Physician/practitioner may develop by interview any additional medical history deemed important, and record any significant findings here.)*

a. COMMENTS

b. TYPED OR PRINTED NAME OF EXAMINER *(Last, First, Middle Initial)*	c. SIGNATURE	d. DATE SIGNED *(YYYYMMDD)*

BACK

NSN 7540-01-075-3786

MEDICAL RECORD

EMERGENCY CARE AND TREATMENT (*Patient*)

LOG NUMBER | TREATMENT FACILITY

RECORDS MAINTAINED AT

PATIENT'S HOME ADDRESS OR DUTY STATION

STREET ADDRESS

CITY | STATE | ZIP CODE

ARRIVAL

DATE *(Day, Month, Year)* | TIME

TRANSPORTATION TO FACILITY

SEX	DUTY/LOCAL PHONE		MILITARY STATUS				THIRD PARTY INSURANCE		
	AREA CODE	NUMBER	ITEM	YES	NO	N/A	ITEM	YES	NO
			PRP				ADDITIONAL INSURANCE		
AGE	HOME PHONE		FLYING STATUS				DD 2568 IN CHART		
		NUMBER	MEDICAL HISTORY OBTAINED FROM				NAME OF INSURANCE COMPANY		

CURRENT MEDICATIONS

ALLERGIES

INJURY OR OCCUPATIONAL ILLNESS

	YES	NO	WHEN *(DATE)*
IS THIS AN INJURY			WHERE
INJURY/SAFETY FORMS			
HOW			

EMERGENCY ROOM VISIT

DATE LAST VISIT

24 HOUR RETURN ☐ YES ☐ NO

TETANUS

DATE LAST SHOT

COMPLETED INITIAL SERIES ☐ YES ☐ NO

CHIEF COMPLAINT

CATEGORY OF TREATMENT

☐ EMERGENT

☐ URGENT

☐ NON-URGENT

TIME

INITIALS

VITAL SIGNS

TIME					
B/P					
PULSE					
RESP					
TEMP					
WT					

LAB ORDERS

☐ CBC/DIFF	☐ ABG	☐ PT/PTT	☐ BHCG/URINE/BLOOD/QUANT		
☐ URINE C&S	☐ UA		☐ CHEM:		
☐ BLOOD C&S X					

X-RAY ORDERS

☐ CXR PA & LAT/ PORTABLE	☐ C-SPINE		
☐ ACUTE ABDOMEN	☐ LS SPINE		
☐ ANKLE R/L	☐ HEAD CT		

ORDERS

☐ PULSE OX ☐ MONITOR ☐ ECG

TIME	ORDERS	BY	COMPLETED BY	TIME	PATIENT'S RESPONSE

DISPOSITION

☐ HOME ☐ FULL DUTY

DISPOSITION QUARTERS/OFF DUTY

☐ 24 HRS. ☐ 48 HRS. ☐ 78 HRS

PATIENT/DISCHARGE INSTRUCTIONS

MODIFIED DUTY UNTIL

RETURN TO DUTY

CONDITION UPON RELEASE

☐ IMPROVED ☐ UNCHANGED

☐ DETERIORATED

ADMIT TO UNIT/SERVICE

TIME OF RELEASE

REFERRED | TO | WHEN

I have received and understand these instructions.

PATIENT'S SIGNATURE

PATIENT'S IDENTIFICATION *(For typed or written entries, give: name-last, first, middle; ID no. (SSN or other); hospital or medical facility)*

EMERGENCY CARE AND TREATMENT (*Patient*)
MEDICAL RECORD
STANDARD FORM 558 (REV 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

NSN 7540-01-075-3786

MEDICAL RECORD	EMERGENCY CARE AND TREATMENT *(Doctor)*	TIME SEEN BY PROVIDER

TEST RESULTS

CBC	WBC	SMAC		ABG/PULSE OX			**RADIOLOGY**	CHECK IF READ BY RADIOLOGIST	☐	
	H/H			SUP 02	PH	PO2	RESULTS			
	PLT			PCO2	SAT	OTHER				
				U/A	DIP		EKG INTERPRETATION			
PT					MICRO					
APTT		BHCG	ETOH	GLU						

PROVIDER HISTORY/PHYSICAL

CONSULT WITH	TIME	ACTION	RESIDENT/MEDICAL STUDENT SIGNATURE AND STAMP
			PROVIDER SIGNATURE AND STAMP
DIAGNOSIS			CODES

PATIENT'S IDENTIFICATION (*For typed or written entries, give: Name-last, first ,middle; ID no. (SSN or other); hospital or medical facility)*

EMERGENCY CARE AND TREATMENT (*Doctor)*
MEDICAL RECORD
STANDARD FORM 558 (REV 9-96)
Prescribed by GSA/ICMR
FPMR (41 CFR) 101-11.203(b)(10)

MEDICAL RECORD	NARRATIVE SUMMARY (CLINICAL RESUME)	
DATE OF ADMISSION	DATE OF DISCHARGE	NUMBER OF DAYS HOSPITALIZED

(Sign and date at end of narrative)

SIGNATURE OF PHYSICIAN	DATE	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give: Name last, first; middle; grade; rank; rate ;hospital or medical facility)	REGISTER NO.	WARD NO.

NARRATIVE SUMMARY (CLINICAL RESUME)

MEDICAL RECORD
STANDARD FORM 502 (rev-7-91)
Prescribed by GSA/ICMR,FIRMR
(41-CFR) 201-9.202.1

MEDICAL RECORD	CONSULTATION SHEET	
REQUEST		
TO:	FROM: *(requesting physician or activity)*	DATE OF REQUEST
REASON FOR REQUEST *(Complaints and findings)*		
PROVISIONAL DIAGNOSIS		
DOCTOR'S SIGNATURE	APPROVED	PLACE OF CONSULTATION ☐ BEDSIDE ☐ ON CALL / ☐ROUTINE ☐ TODAY ☐72 HOURS ☐ EMERGENCY
CONSULTATION REPORT		
RECORD REVIEWED ☐ YES ☐ NO	PATIENT EXAMINED ☐ YES ☐ NO	TELEMEDICINE ☐ YES ☐ NO

SIGNATURE AND TITLE			DATE
HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT	DEPARTMENT/SERVICE OF PATIENT	
RELATION TO SPONSOR	SPONSOR'S NAME *(last, first, middle)*	SPONSOR'S ID NUMBER	
PATIENT'S IDENTIFICATION *(For typed or written entries, give: Name –last, first, middle; ID No.(SSN or other); Sex; Date of Birth; Rank/Grade)*		REGISTER NO.	WARD NO.

CONSULTATION SHEET
MEDICAL RECORD
STANDARD FORM 513 (Rev. 4-98)
Prescibed by GSA/ICMR FPMR (41 CFR) 101-11.203(b)(10)

Clinical Record	ELECTROCARDIOGRAPHIC RECORD	Previous ECG ☐ Yes ☐ NO

Clinical Impression	Medication	☐ Emergency ☐ Routine	☐ Bedside ☐ Ambulant

Age	Sex	Race	Height	B.P.	Signature of Ward Physician	Date

Rhythm	Axis Deviation	Rates Auric. Vent.

IIntervals PR QRS QT	P Waves

QRS Complexes

RS-T Segment	T Waves

Unipolar Extremity Leads *(specify)*

Precordial Leads *(specify)*

Summary, Serial Changes, and Implications:

(Continue on Reverse)

No. ECG	Signature of Physician	Patient's Identification No.	Date

Patient's Identification (For typed or written entries give; Name – Last First, middle; grade, date hospital or medical facility)	Register No.	Ward No.

Electrocardiographic Records
Standard Form 520
General Services Administration and
Interagency Committee on Medical Records
FPMR 101-11.806-8
October 1975 520-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	TISSUE EXAMINATION

SPECIMEN SUBMITTED BY | DATE OBTAINED

SPECIMEN

BRIEF CLINICAL HISTORY *(include duration of lesion and rapidity of growth, if a necoplasm)*

PREOPERATIVE DIAGNOSIS

OPERATIVE FINDINGS

POSTOPERATIVE DIAGNOSIS | SIGNATURE | NAME OF SIGNER | TITLE OF SIGNER

PATHOLOGICAL REPORT

NAME OF LABORATORY | ACCESSION NO(S)

GROSS DESCRIPTION, HISTOLOGIC EXAMINATION AND DIAGNOSES

SIGNATURE OF PATHOLOGIST | NAME OF PATHOLOGIST | DATE

HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT | DEPARTMENT/SERVICE OF PATIENT

RELATION TO SPONSOR | SPONSOR'S NAME (*Last, first middle)* | SPONSOR'S ID NUMBER (*SSN or Other)*

PATIENT'S IDENTIFICATION (For typed or written entries, give: Name-last, first, middle; ID no. SSN or other); Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

TISSUE EXAMINATION
Medical Record

STANDARD FORM 515 (Rev 8-97)
Prescribed by GSA/ICMR FPMR 101-11.203(b)(10)

Medical record	GYNECOLOGIC CYTOLOGY

Section I – Clinical data to be Completed by Examining Installation

Date Obtained	LMP First Day	Date Received in Laboratory

Source of Specimen

☐ Combined Cerve and Vagina ☐ Cerve ☐ Vagina ☐ Other (Specify)

Age	Pregnancy ☐ Yes ☐ No	Gravida	Para	Previous Abnormal Cytologic Examination ☐ Yes, Give Date_____ ☐ No

Clinical History *(Surgery, Drugs, hormones, radiation, etc.)*	Physical Examination *(Pelvic findings, etc.)*

Specimen Submitted By *(Facility)*	Signature and title	Submitting Facility Accession Number

Section II – Cytologic Findings Form Reporting Installation Only

Name of Laboratory	Accession Number

Check One	Yes	No	Check One	Yes	No	
Granulocytes			Endocervial Cells			Maturation Index
Leukocytes						Parabasals
Trichamonas			Screened By			Intermediates
Candida						Superficials

Comments and recommendations

SAMPLE FORM

Pathologist's Signature	Title	Date

Patients Identification (For typed or written entries give; Name – Last first, Middle; grade, date, hospital or medical facility)	Register No.	Ward No.

Standard form 541
Provided by GSA and ICMB

Encl. (1) to CHAP 4, COMDTINST M6000.1B

CLINICAL RECORD	LABORATORY REPORTS

ATTACH 3D REPORT ALONG HERE AND ↖ SUCCEEDING ONES ON ABOVE LINES

ATTACH 2D REPORT WITH TOP AT THIS LINE ↖

ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↖

ATTACHING MARGIN

ATTACH ALL TEST REPORTS TO THIS SHEET

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; grade; date; hospital or medical facility)*,	REGISTER NO.	WARD NO.

LABORATORY REPORTS

Standard Form 514
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505
October 1975 514-108

MEDICAL RECORD	RADIOLOGICAL CONSULTATION REQUESTS/REPORTS
	ATTACH 3D REPORT ALONG HERE ↖ AND SUCCEEDING ONES ON ABOVE LINES
	ATTACH 2D REPORT WITH TOP AT THIS LINE ↖
ATTACH REPORTS WITHIN THIS MARGIN	ATTACH 1ST REPORT ALONG LEFT MARGIN WITH TOP AT THIS LINE ↖

RADIOLOGICAL CONSULTATIONS REQUESTS/REPORTS
STANDARD FORM 519 (Rev. 2-84)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201.45.505
519-11
NSN 7540-00-634-4160

BACK

(THIS FORM IS SUBJECT TO THE PRIVACY ACT OF 1974 – Use DD Form 2006.)

EYEWEAR PRESCRIPTION	**DATE**	**ACCOUNT NUMBER**	**ORDER NUMBER**
TO: *(LAB)*		**FROM:**	
NAME *(Last, First)*		**SSN**	**GRADE**
ADDRESS/UNIT			**PHONE**
ADDRESS CONTINUED			**SHIP TO:** ☐ **CLINIC** ☐ **PATIENT**
CITY, STATE, ZIP			

SAMPLE FORM

AD	RES	NG	RET	OTHER	A	N	AF	MC	CG	PHS	OTHER

FRAME	**EYE**	**BRIDGE**	**TEMPLE**	**COLOR**

DIST / **NEAR** **PD**	**LENS**	**TINT**	**MATERIAL**	**PAIR**	**CASE**

	SPHERE	CYLINDER	AXIS	DECENTER	H PRISM	H BASE	V PRISM	V BASE
R								
L								

MULTIVISION			**LAB USE**	
NEAR ADD	SEG HT	TOTAL DECENTER		
			PRIORITY	**TECH INITIALS**

SPECIAL COMMENTS/JUSTIFICATION *(* Use this space to specify blocks marked "Other.")*

PRESCRIBING OFFICER/AUTHORITY	SIGNATURE

DISTRIBUTION: ORIGINAL – Retained by Lab. **COPY 1** – Returned with eyewear. **COPY 2 –** Entered in health record.

DD FORM 771, JUL 96 (EG) PREVIOUS EDITION IS Designed using Perform Pro, WHS/DIOR, Aug 96

BACK

HEALTH RECORD **IMMUNIZATION RECORD** *All entries in ink to be made in block letters*

VACCINATION AGAINST SMALLPOX *(Number of previous vaccination scars)*

	DATE	ORIGIN	BATCH NUMBER	REACTION	STATION	PHYSICIAN'S NAME
1						
2						
3						
4						
5						
6						

YELLOW FEVER VACCINE

	DATE	ORIGIN	BATCH NUMBER	STATION	PHYSICIAN'S NAME
1					
2					
3					

TYPHOID VACCINE

	DATE	DOSE	PHYSICIAN' NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

TETANUS-DIPHTHERIA TOXOIDS

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				4			
2				5			
3				6			

CHOLERA VACCINE

	DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME		DATE	PHYSICIAN'S NAME
1			4			7		
2			5			8		
3			6			9		

PATIENTS IDENTIFICATION *(Mechanically Imprint, Type or Print):*

◀ Patient's Name – last, first, middle initial; Sex; age or Year Of Birth; Relationship to Sponsor; Component/Status; Department/Service.

◀ Sponsor's Name – last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

IMMUNIZATION RECORD
Standard Form 601 – October 1975 (Rev.)
General Services Administration & Interagency Committee on Medical Records
FIRMR (41 CFR) 201-45.505

ORAL POLIOVIRUS VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE

	DATE	DOSE	PHYSICIAN'S NAME		DATE	DOSE	PHYSICIAN'S NAME
1				3			
2				4			

INFLUENZA VACCINE

	DATE	TYPE	DOSE	PHYSICIAN'S NAME		DATE	TYPE	DOSE	PHYSICIAN'S NAME
1					5				
2					6				
3					7				
4					8				

SENSITIVITIES TEST *(Tuberculin,etc.)*

	DATE	TYPE	DOSE	ROUTE	RESULTS	PHYSICIAN'S NAME
1						
2						
3						
4						
5						

REMARKS:

THIS RECORD IS ISSUED IN ACCORDANCE WITH ARTICLE 99, WHO SANITARY REGULATION NO 2.

STANDARD FORM 601 PAGE 2 (Rev. 10-75)

HEALTH RECORD SYPHILIS RECORD

SECTION 1. – HISTORY OF PAST VENEREAL INFECTIONS OR TREATMENTS

	DATE	DISEASE *(Give stage)*	PRIOR TO MIL. SERVICE YES	PRIOR TO MIL. SERVICE NO	TREATMENT *(Give type, amount and dates)*	TREATING AGENCY	PLACE
1							
2							
3							
4							

SECTION II = HISTORY OF PRESENT INFECTION

CAME TO MEDIAL ATTENTION BY: **VOLUNTARY** ☐ CONTACT REPORT ☐ PHYSICAL INSPECTION ☐ FOOD HANDLER ☐

INCIDENT TO HOSPITALIZATION **PREMARITAL** ☐ **PRENATAL** ☐ **OTHER** *(Specify)* ☐

DATES: ONSET SYMPTOMS	**REQUESTED TREATMENT**	**DIAGNOSIS ESTABLISHED**

DIAGNOSIS *(Include stage and diagnosis No.)*

DIAGNOSTIC CRITERIA *(Enter results of test)*

LIST VD CONTACT FORM SERIAL NOS.

CLINICAL DATA *(Including chief complaint, physical findings – eye, cardiovascular and nervous system, even in early syphillis)*

SAMPLE FORM

RECOMMENDED TREATMENT AND FOLLOW-UP	**SIGNATURE OF PHYSICIAN**	**DATE**

HAVE BEEN INFORMED BY THE MEDICAL OFFICER THAT I HAVE BEEN DIAGNOSED AS HAVING SYPHILIS AS INDICATED ABOVE; THE NATURE OF THIS DISEASE HAS BEEN EXPLAINED TO ME; I UNDERSTAND THAT MY COOPERATION IS NECESSARY IN THE TREATMENT AND PROLONGED OBSERVATION *(including certain prescribed tests)* FOR THE CARE OF THIS DISEASE.

SIGNATURE OF PATIENT AND DATE

SECTION III. - TREATMENT

	TREATMENT	DATE STARTED	DATE ENDED	SIGNATURE OF PHYSICIAN
1				
2				
3				
4				

PATIENT'S IDENTIFICATION *(Mechanically Imprint, Type or Print):*

◀ Patient's Name – last, first, middle initial; Sex; age or Year Of Birth; Relationship to Sponsor; Component/Status; Department/Service.

◀ Sponsor's Name – last, first, middle initial; Rank/Grade; SSN or Identification Number; Organization.

SYPHILIS RECORD
Standard Form 602 – March – 1975 (Rev.)
General Services Administration &
Interagency Comm on Medical Records

SECTION IV. – CUMULATIVE LABORATORY SUMMARY

RESULTS OF DARKFIELD EXAMINATION

	DATE	RESULTS	SOURCE OF SPECIMEN	LABORATORY	NAME OF CONFIRMING OFFICER
1					
2					

RESULTS OF SEROLOGICAL TESTS FOR SYPHILIS

	DATE	TYPE	RESULT *(Include titer value)*	LABORATORY		DATE	TYPE	RESULT *(Include Titer value)*	LABORATORY
1					5				
2					6				
3					7				
4					8				

FLUORESCENT ANTIBODY TESTS

	DATE	
1		
2		

RESULTS OF SPINAL FLUID EXAMINATION

	DATE	CELLS	TOTAL PROTEIN	SEROLOGICAL TEST *(Including titer)*	LABORATORY WHERE DONE
1					
2					

SECTION V. – EVALUATION OF THERAPY

	DATE	FACILITY WHERE EVALUATED	RESULT		DATE OF RETREATMENT	PHYSICIAN'S SIGNATURE
			Satisfactory	UNSATISFACTORY		
1						
2						
3						
4						

***Satisfactory result cannot be reported without normal spinal fluid findings.**
****Specify: Infectious Relapse: Sero-Relapse, Neuro-Relapse, Incomplete data on Spinal Fluid, Other** *(Specify)*

REASON FOR INADEQUATE FOLLOW-UP *(Date, place and type of separation – Give authority for discharge)*

PATIENT'S HOME ADDRESS ON SEPARATION	**CIVILIAN HEALTH DEPT. TO WHICH CASE RESUME WAS SENT**

REINFECTION *(Give date new record was opened)*

REMARKS

SECTION VI. – MEDICAL OFFICER CLOSING THIS RECORD

NAME *(Typed or printed)*	**SIGNATURE**	**STATION**	**DATE**

SECTION VII. – MEDICAL OFFICER SENDING ABSTRACT TO VETERAN'S ADMINISTRATION ON DISCHARGE

NAME *(Typed or printed*	**SIGNATURE**	**STATION**	**DATE**

Page 2 of SF-602 (rev. 3-75)

BACK

RECORD OF OCCUPATIONAL EXPOSURE TO IONIZING RADIATION

For instructions See Reverse of Sheet

Identification Number	Name (*Last, First, Middle Initial)*	Social Security Number	Rank/Rate/Title	Date of Birth

Place Where Exposure Occurred	Period of Exposure	**Dose This Period** 1. Method of monitoring is presumed to be film badge reading unless otherwise specified under item 16, "REMARKS."	**Accumulated Dose**	Initial

Acticty	From (Day-Mo-Yr)	To (Day-Mo-Yr)	Skin Dose (Salt)	Gamma and X-Ray	Neutron	Total This Period	Total Life Time	Permis-sible Lifetime	Persons Making Entry

16. Remarks:

TO BE RETAINED PERMANENTLY IN INDIVIDUAL'S MEDICAL RECORD

DD Form 1141

Back

Department of Transportation U.S. Coast Guard CG-4057 (Rev 2-01)	CHRONOLOGICAL RECORD OF SERVICE	
DATE ATTACHED	**UNIT OR STATION**	**DATE DETACHED**
Name (Last, First, Middle)		**Social Security Number**

Page 2 of 2 CG-4057 (Rev 2-01)

AGREEMENT/DISAGREEMENT

I agree ☐ (or) do not agree ☐ that at the time of separation:

(2) I am reasonably able to perform my current duties, or

(2) I have a high expectation of recovery in the near term from illness, injury or surgical procedure such that I would again be able to perform my usual duties.

Date	Grade/Rate	Signature of Member

TERMINATION OF HEALTH RECORD

Remarks

Impairments, which have been documented in your health record, including any separation exam, while establishing service connection, do not in themselves indicate a disability. To receive disability benefits from the Coast Guard, you must be found unfit to perform your assigned duties through the physical disability evaluation system before you are separated.

After you are separated, any claims for disability benefits must be submitted to the Department of Veterans Affairs. If you have questions about certain benefits to which you might be entitled you should contact the DVA Regional Office nearest your home as soon as practical.

I have read the above statements and acknowledge receipt of a copy of the following:

1. CG-4057, Chronological record of Service.
2. SF-88 report of Medical Examination date_____ (if performed).
3. PHS-731, International Certificate of Vaccination.
4. DD Form 2766, Adult Preventive and Chronic Care Flowsheet.

Date	Grade/Rate	Signature of Member

COMMAND CERTIFICATION

Health record terminated this date by reason of_____

In accordance with Chapter 4, Medical Manual, COMDTINST M6000.1 (series)

Date	Title	Signature

NAVMED – 6150/2 (REV 8-70)	**SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)**
Health Record	**Special Duty Medical Abstract**

Summary of Physical Examination for Special Duty

Date	Place	Purpose	Result – Recommendation *(Defects Reverse)*	BUMED Action	Sig. Of M.D.
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					

Suspension From Special Duty

Date *(From) (To)*	No. of Days	Reason for Suspension	Signature of Medical Officer
1.			
2.			
3.			
4.			
5.			
6.			
7.			

Periodic Special Duty Requalification

Date	Signature of . O.	Date	Signature of M.O.	Date	Signature of M.O.

Name (Last) (First) (Middle)	Grade/Rate	Service/Soc. Sec.	Organization

SPECIAL DUTY MEDICAL ABSTRACT (NAVMED 6150/2)

Altitude Training, Air Compression and Oxygen Tolerance			
Date	Station	Type of Run – Reaction	Signature or M.O.
1.			
2.			
3.			
4.			
5.			
Explosive Decompression Training			
Date	Station	Altitudes - Reaction	Signature or M.O.
1.			
2.			
Submarine Escape and Diving Training			
Date	Station	Type of Run - Reaction	Signature or M.O.
1.			
2.			
3.			
4.			
5.			
Visual and Disorientation Training			
Date	Station	Type of Training	Signature or M.O.
1.			
2.			
3.			
4.			
Centrifuge and Ejection Seat Training			
Date	Station	Type of run – Reaction	Signature or M.O.
1.			
2.			
Remarks			

BACK

EMERGENCY MEDICAL TREATMENT REPORT

VICTIM IDENTI-FICATION

1. Name_____
_____
2. Sex (check one) male _____
female _____
3. Estimated age yrs_____ mos_____

RESCUER INFOR-MATION

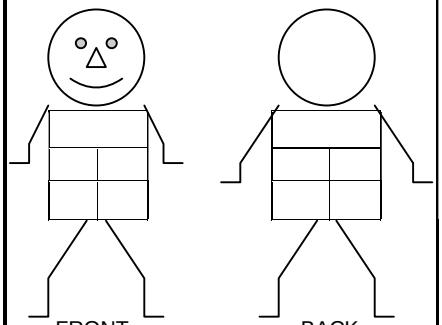
10. Name: _____ 11. Level:
12. Unit: _____
13. OPFAC #: _____
14. Rescue Vehicle:_____
15. Receiving Unit:_____
16. Time Patient Transferred:_____

DESCRIP-TION OF INCIDENT

4. Date: _____ 5. Type of incident:
6. Time on Scene: _____ a) marine _____
7. Time of incident: _____ b) aviation _____
c) Industrial _____
8. Location:_____ d) auto _____
_____ e) domestic _____
f) other _____

NATURE OF EMERGENCY / MECHANISM OF INJURY

OBSERVA-TION OF VISTIM



H – hemorrhage **F –** fracture
L - laceration **B -** burns
S – soft tissue injury O2 Liters_____

TREATMENT

IRCLE AS NEEDED)

– DRESSING
- TX SPLINT
- SPLINT
- C/COLLAR
- BACK BOARD
- TOURNIQUET
- CPR
- AIRWAY
- OXYGEN
.0 - MAST
.1 - MILLER B/B

MEDICATIONS:

ALLERGIES

_____

MEDICAL HISTORY / COMMENTS /ETC.
(include additional vitals, oxygen, fluids, etc.)

SKIN

(Circle appropriate number of numbers)
1 – normal 4 - cyanotic 7 - cold
2 – pale/ashen 5 – dry 8 – warm
3 – flushed 6 – moist 9 - hot

VITAL SIGNS

TIME / OBSERVED				
LEVEL OF CONSCIOUS				
Alert				
Responds to Verbal				
Responds to Pain				
Uncon/Unresponsive				
PUPILS				
Perl				
Unequal				
Nonreactive				
Dilated				
Pinpoint				
PULSE				
Rate (Numeric)				
Strong				
Weak				
BREATHING				
Rate (Numeric)				
Regular				
Shallow				
Labored				
BLOOD PRESSURE				
Blood Pressure	/	/	/	/
TEMP				
Temperature ORAL (circle) RECTAL				
MAST				
MAST BP	/	/	/	/
COMPARTMENT		R	L	ABD

TIME	MEDICATIONS ADMINISTERED	DOSAGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

TRIAGE INFORMATION (CIRCLE ONE) **PRIORITY I** **PRIORITY II** **PRIORITY III**

DEPT. OF TRANSPORTATION., USCG CG-5214 (Rev. 10-88) **PATIENT COPY**
Previous Edition May be Used

REQUEST FOR MEDICAL/DENTAL RECORD OR INFORMATION	REQUESTING ACTIVITY Complete Items 1 through 10 *(Except 8b); also* Complete Item 19. ADDRESSEE – Complete Items 8b, 11 to 14 or 15 to 18, as appropriate, Final referrer shall return to requester.	Date

1. PATIENT *(Last Name – First Name – Middle Name)*

2. ORGANIZATION AND PLACE OF TREATMENT

3. STATUS ☐ MILITARY ☐ VA BENEFICIARY ☐ DEPENDENT ☐ FEDERAL EMPLOYEE ☐ OTHER *(Specify)*

3a. NAME OF SPONSOR *(If dependent)*

4. TO *(Include ZIP Code)*

5. IDENTIFYING INFORMATION
- a. SERVICE NUMBER
- b. GRADE/RATE
- C. SOCIAL SECURITY ACCOUNT NO.
- D. VA CLAIM NUMBER
- E. DATE OF BIRTH *(If federal employee)*

6. DATES OF TREATMENT

7 DISEASE OR INJURY

8. a. RECORDS REQUESTED B. RECORDS FORWARDED

	MIL a.	VA a.	MIL B.	VA B.
CLINICAL	☐	☐	☐	☐
OUTPATIENT	☐	☐	☐	☐
HEALTH RECORD	☐		☐	
DENTAL RECORD	☐	☐	☐	☐
X--RAY	☐	☐	☐	☐
MEDICAL REPORT CARDS, EMERGENCY MEDICAL TAGS, FIELD MEDICAL CARDS	☐		☐	
ABSTRACT OF RATING SHEET			☐	
REPORT OF PHYSICAL EXAMINATION	☐	☐	☐	☐
ALL AVAILABLE RECORDS *(Except X-rays unless specifically requested)*	☐		☐	
OTHERS *(List under remarks)*	☐	☐	☐	☐

9. REMARKS

SAMPLE FORM

10. SIGNATURE

REPLY/REFERRAL

11. TO:

12. REMARKS
- RECORDS CHECKED IN 8B FORWARDED.
- NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
- MORE INFORMATION NEEDED.

13. SIGNATURE

14. DATE

REPLY/SECOND REFERRAL

15. TO:

16. REMARKS
- RECORDS CHECKED IN 8B FORWARDED.
- NO RECORDS FOUND FOR PATIENT DURING ABOVE PERIOD.
- MORE INFORMATION NEEDED.

17. SIGNATURE

18. DATE

19. **RETURN TO**: *(Include ZIP Code)*

REQUESTING ACTIVITY WILL ENTER COMPLETE ADDRESS TO WHICH RECORDS OR FINAL REPLY SHOULD BE MAILED.

DD FORM 877, SEP 67

U. S. COAST GUARD

DENTAL RECORD

PRIVACY ACT STATEMENT: HEALTH CARE RECORDS

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** Section 632 of Title 14 United States Code and Sections 1071-1087, Title 10 United States code, Executive Order9397.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:** The purpose for requesting information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The social Security Number (SSN) necessary to identify the person and records.

3. **ROUTINE USES:** This information may be used to plan and coordinate health care. It may be used to provide medical treatment, conduct research, teach, compile statistical data, determine suitability of persons for service or assignment, implement preventive health and communicative disease control program; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification of patients to other Federal, State and local agencies upon request in the pursuit of there official duties; and report medical conditions required by law to federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.

4. The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.

5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

LAST NAME FIRST NAME MIDDLE NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH *(DAY, MO,YR)*

GRADE OR RATE	CHANGES IN GRADE OR RATE			

BLOOD TYPE *(Check one)*			
☐ O	☐ A	☐ B	☐ AB

RH FACTOR *(Check one)*	
☐ POSTIVE	☐ NEGATIVE

DRUG SENSITIVITY
SPECIFIC DRUG(S)

ATTACH TO FRONT OF CHART JACKET

DEPT OF TRANSP. USCG CG 3443-2

DENTAL HEALTH QUESTIONNAIRE

Personal Data - Privacy Act of 1974

ARE YOU IN FLIGHT STATUS? . . . YES ☐ NO ☐ | OCCUPATION/JOB:

ARE YOU PRESENTLY ILL OR UNDER THE CARE OF A PHYSICIAN? . . . . **YES** ☐ **NO** ☐

IF YES, PLEASE DESCRIBE: _____

ALLERGIES (including medication, Latex, jewelry, metal, etc.): _____

CURRENT MEDICATIONS: _____
(including aspirin, over-the-counter medications, etc.): _____

HISTORY OF HOSPITALIZATIONS: _____

ANY FAMILY HISTORY OF: Heart Disease ☐ Cancer ☐ Diabetes ☐ Seizures ☐

HAVE YOU EVER HAD OR DO YOU NOW HAVE:

	Yes	No	Don't Know		Yes	No	Don't Know		Yes	No	Don't Know
Epilepsy or Seizures				Hemophilia				Ulcers			
Fainting or dizziness				Bruise or bleed easily				Kidney problems			
Anxiety reaction				Heart problems/Angina				Venereal disease			
Stroke				Hypertension				Diabetes			
Glaucoma				Rheumatic fever				Thyroid disease			
Cold Sores (Herpes)				Heart murmur				HIV/AIDS			
Persistent cough				Mitrol valve prolapse				Arthritis			
Emphysema				Congenital heart lesions				Painful joints (incl. jaw)			
TB/PPD positive				Heart surgery				Prosthetic joint			
Asthma				Prosthetic heart valve				Hives			
Hay Fever				Pacemaker				Steroid medication			
Sinus problems				Blood transfusions				Drug addiction			
Anemia				Liver disease				Alcoholism			
Sickle cell disease				Yellow jaundice				Unexplained weight change			
G-6-PD deficiency				Hepatitis - type:				Cancer/radiation therapy			

HAVE YOU EVER BEEN TOLD THAT YOU SHOULD NOT DONATE BLOOD? ----------
HAVE YOU EVER BEEN TOLD THAT YOU NEED ANTIBIOTICS BEFORE DENTAL TREATMENT? ----------
FEMALES: Are you taking birth control pills? ----------
Are you or might you be pregnant? Estimated delivery: _____
DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEM NOT LISTED ABOVE? Please describe: _____

_____ _____
Patient's signature Date

SUMMARY OF PERTINENT FINDINGS / RECOMMENDED TREATMENT MODIFICATIONS (Dentist's use only) B/P: _____

WELLNESS SCREEN:

Tobacco use _____ Exercise _____ Diet/nutrition _____
Alcohol use _____ Stress _____ Seat belt use _____

_____ _____
Dental Officer's Signature Date

PATIENT'S IDENTIFICATION	PATIENT'S NAME (Last, First, MI)		SEX
	DATE OF BIRTH	RELATIONSHIP TO SPONSOR	SERVICE
	SPONSOR'S NAME		RANK/GRADE
	SSN	ORGANIZATION/COMMAND	
	PHONE #: DAY	EVENING	

DEPT. OF TRANSP., USCG, CG-5605 (4-96)

GENERAL SERVICES ADMINISTRATION
INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201–45.505

HEALTH RECORD — **DENTAL**

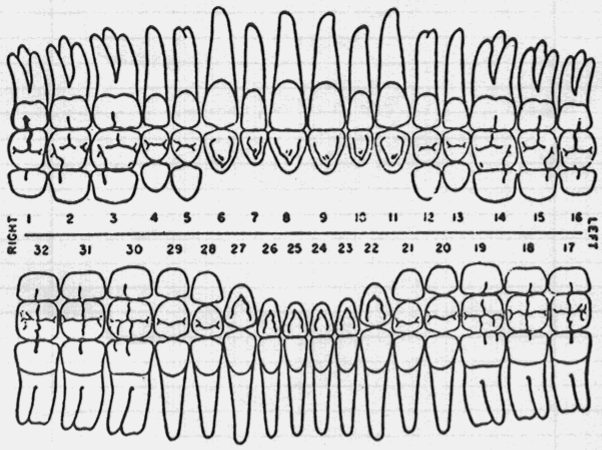
SECTION I. DENTAL EXAMINATION

1. PURPOSE OF EXAMINATION: INITIAL | SEPARATION | OTHER (*Specify*)

2. TYPE OF EXAM. 1 2 3 4

3. DENTAL CLASSIFICATION 1 2 3 4 5

4. MISSING TEETH AND EXISTING RESTORATIONS

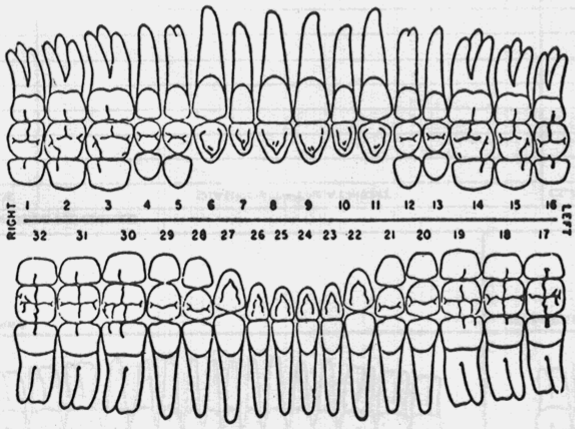


REMARKS

PLACE OF EXAMINATION | DATE

SIGNATURE OF DENTIST COMPLETING THIS SECTION

5. DISEASES, ABNORMALITIES, AND X-RAYS



A. CALCULUS: SLIGHT | MODERATE | HEAVY

B. PERIODONTOCLASIA: LOCAL | GENERAL; INCIPIENT | MODERATE | SEVERE

C. STOMATITIS (*Specify*)

GINGIVITIS | VINCENT'S

D. DENTURES NEEDED
(*Include dentures needed after indicated extractions*)

FULL		PARTIAL	
U	L	U	L

ABNORMALITIES OF OCCLUSION—REMARKS

E. INDICATE X-RAYS USED IN THIS EXAMINATION

FULL MOUTH PERIAPICAL | POSTERIOR BITE-WINGS | OTHER (*Specify*)

DATE | PLACE OF EXAMINATION | SIGNATURE OF DENTIST COMPLETING THIS SECTION

SECTION II. PATIENT DATA

6. SEX | 7. RACE | 8. GRADE, RATING, OR POSITION | 9. ORGANIZATION UNIT | 10. COMPONENT OR BRANCH | 11. SERVICE, DEPT., OR AGENCY

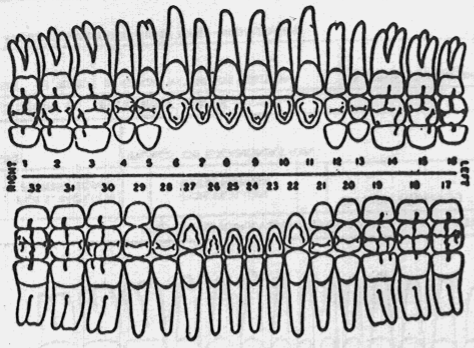
12. PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME | 13. DATE OF BIRTH (DAY–MONTH–YEAR) | 14. IDENTIFICATION NO.

NSN 7540-00-634-4179

DENTAL
Standard Form 608
603–104

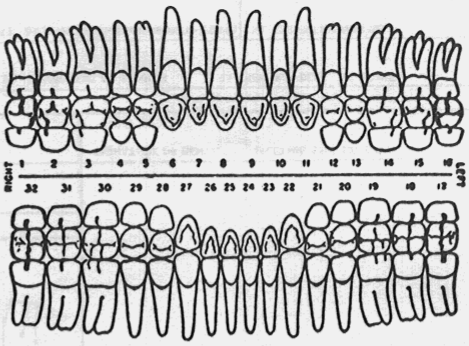
SECTION III. ATTENDANCE RECORD

15. RESTORATIONS AND TREATMENTS (*Completed during service*)



REMARKS

16. SUBSEQUENT DISEASES AND ABNORMALITIES



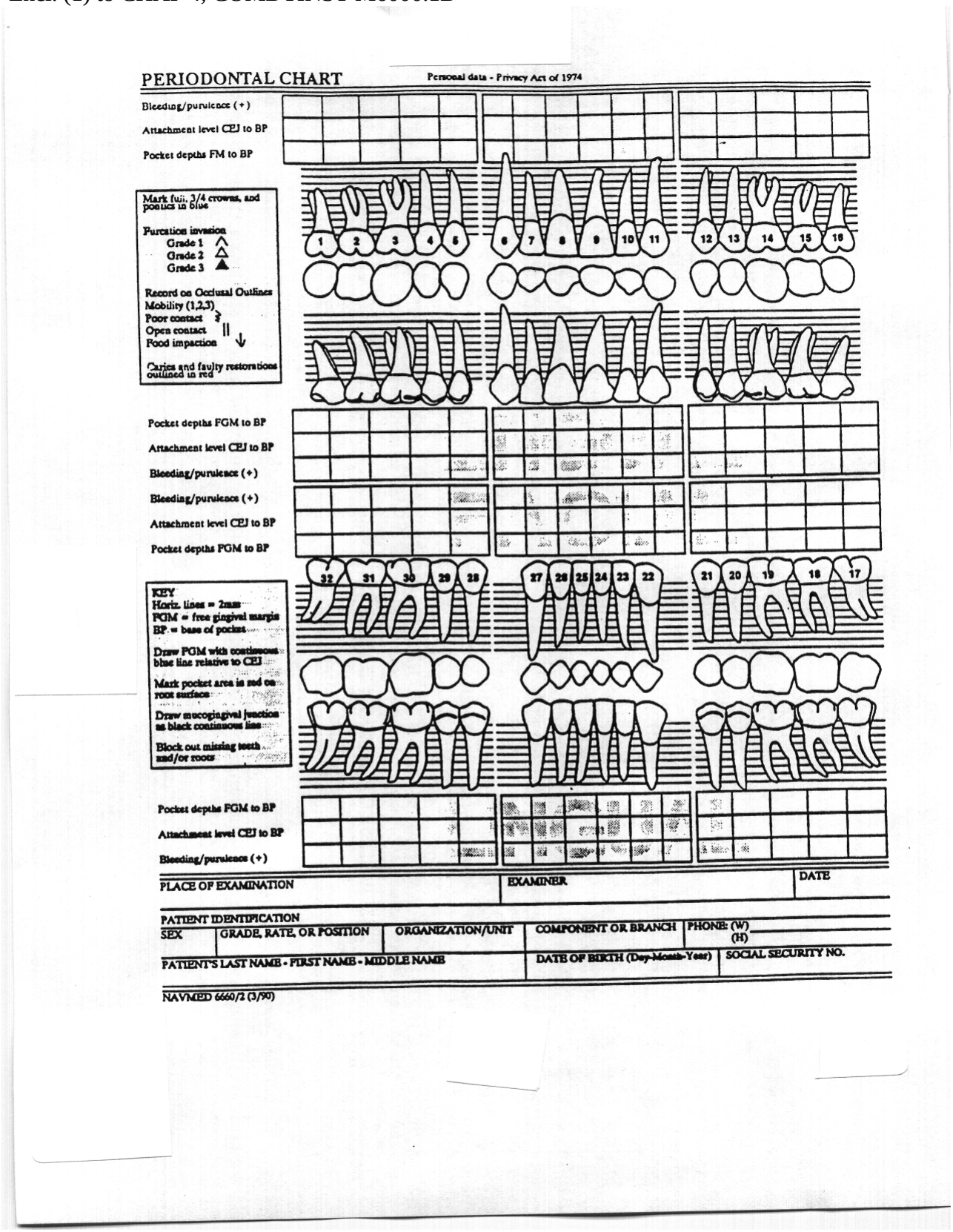
REMARKS

17. SERVICES RENDERED

DATE	DIAGNOSIS—TREATMENT	CLASS	OPERATOR AND DENTAL FACILITY	INITIALS

PATIENT'S LAST NAME—FIRST NAME—MIDDLE NAME

☆U.S. GOVERNMENT PRINTING OFFICE: 1985 O - 491-248 (20242)



PERIODONTAL CHART

Personal data - Privacy Act of 1974

Bleeding/purulence (+)
Attachment level CEJ to BP
Pocket depths FM to BP

Mark fuji, 3/4 crowns, and pontics in blue

Furcation invasion
Grade 1
Grade 2
Grade 3

Record on Occlusal Outlines
Mobility (1,2,3)
Poor contact
Open contact
Food impaction

Caries and faulty restorations outlined in red

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16

Pocket depths FGM to BP
Attachment level CEJ to BP
Bleeding/purulence (+)
Bleeding/purulence (+)
Attachment level CEJ to BP
Pocket depths FGM to BP

32 31 30 29 28 27 26 25 24 23 22 21 20 19 18 17

KEY
Horiz. lines = 2mm
FGM = free gingival margin
BP = base of pocket

Draw FGM with continuous blue line relative to CEJ

Mark pocket area in red on root surface

Draw mucogingival junction as black continuous line

Block out missing teeth and/or roots

Pocket depths FGM to BP
Attachment level CEJ to BP
Bleeding/purulence (+)

PLACE OF EXAMINATION | EXAMINER | DATE

PATIENT IDENTIFICATION

SEX | GRADE, RATE, OR POSITION | ORGANIZATION/UNIT | COMPONENT OR BRANCH | PHONE: (W) (H)

PATIENT'S LAST NAME - FIRST NAME - MIDDLE NAME | DATE OF BIRTH (Day-Month-Year) | SOCIAL SECURITY NO.

NAVMED 6660/2 (3/90)

PERIDONTAL CHART

Patient's Name: _____ SSN: _____

Chief Complaint:

_____

Pertinent Med Dent Hx:

Age	Sex	Race	HT	WT	BP

Extraoral Findings:

_____

Intreoral Findings:

_____

Periodontal Findings:

_____

Occlusion:

_____

Pediographic Assesment:

_____

Etiology/Contributing Factors:

_____

Diagnosis:

Prognosis (1-5 years) (Circle One): Good Fair Poor Hopeless

Overall Individual: _____

Tentative Treatment Plan:

_____

_____

_____

LAST NAME	FIRST NAME	MIDDLE NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER (OPTIONAL)

U.S. Coast Guard
CLINICAL RECORD

PRIVACY ACT STATEMENT; HEALTH CARE RECORDS

1. **AUTHORITY FOR COLLECTION OF INFORMATION INCLUDING SOCIAL SECURITY NUMBER (SSN):** Section 632 of Title 14, United States Code and Sections 1071-1087, Title 10 United States Code, Executive Order 9397 and Title 5 United States Code Section 7901.

2. **PRINCIPAL PURPOSES FOR WHICH INFORMATION IS TO BE USED:** The purpose for requesting personal information is to assist medical personnel in developing records to facilitate and document your health condition in order to provide health care and to provide a complete account of such care rendered, including diagnosis, treatment, and end result. The Social Security Number (SSN) is not mandatory; however it is desirable for identification and recall of records.

3. **ROUTINE USES:** The information may be used to plan and coordinate health care. It may be used to provide medical treatment; conduct research; teach; compile statistical data; implement preventive health and communicative disease control programs; adjudicate claims and determine benefits; evaluate care rendered; determine professional certification and hospital accreditation; conduct authorized investigations; provide physical qualifications of patients to other Federal, State and local agencies upon request in the pursuit of their official duties; and report medical conditions required by law to Federal, State and local agencies. It may be used for other lawful purposes including law enforcement and litigation.

4. The above Privacy Act Statement applies to all requests for personal information made by medical treatment personnel or for medical treatment purposes. Failure to provide the requested information for these medical records may result in an inability of Coast Guard medical personnel to afford treatment.

5. No information may be divulged from this record except to persons properly and directly concerned. Questionable cases will be referred to the Commanding Officer for decision.

STATUS

DEPENDENT ☐
RETIREE ☐

USCG ☐
USPHS ☐
USN ☐
USMC ☐
USAF ☐
USA ☐

CIVILIAN EMPLOYEE ☐

OTHER _____ SPECIFY

OCCUPATIONAL MONITORING _____ SPECIFY

MED-ALERT ☐

DEPT. OF TRANSP., USCG, CG—3443—1 (10-77)

MEDICAL RECORD	REQUEST FOR ADMINISTRATION OF ANESTHESIA AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

A. IDENTIFICATION

1. OPERATION OR PROCEDURE

B. STATEMENT OF REQUEST

1. The nature and purpose of the operation or procedure, possible alternative methods of treatment, the risks involved, and the possibility of complications have been fully explained to me. I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure. I understand the nature of the operation or procedure to be _____

(Description of operation or procedure in layman's language)

_____

_____

which is to be performed by or under the direction of Dr. _____

2. I request the performance of the above-named operation or procedure and of such additional operations or procedures as are found to be necessary or desirable, in the judgment of the professional staff of the below-named medical facility, during the course of the above-named operation or procedure.

3. I request the administration of such anesthesia as may be considered necessary or advisable in the judgment of the professional staff of the below-named medical facility.

4. Exceptions to surgery or anesthesia, if any, are: _____

(If "none", so state)

5. I request the disposal by authorities of the below-named medical facility of any tissues or parts which it may be necessary to remove.

6. I understand that photographs and movies may be taken of this operation, and that they may be viewed by various personnel undergoing training or indoctrination at this or other facilities. I consent to the taking of such pictures and observation of the operation by authorized personnel, subject to the following conditions:

a. The name of the patient and his/her family is not used to identify said pictures.
b. Said pictures be used only for purposes of medical/dental study or research.

(Cross out any parts above which are not appropriate)

C. SIGNATURES *(Appropriate items in Parts A and B must be completed before signing)*

1. COUNSELING PHYSICIAN/DENTIST: I have counseled this patient as to the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above.

_____

(Signature of Counseling Physician/Dentist)

2. PATIENT: I understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Patient)*	*(Date and Time)*

3. SPONSOR OR GUARDIAN: (When patient is a minor or unable to give consent) I, _____ sponsor/guardian of _____ understand the nature of the proposed procedure(s), attendant risks involved, and expected results, as described above, and hereby request such procedure(s) be performed.

_____	_____	_____
(Signature of Witness, excluding members of operating team)	*(Signature of Sponsor/Legal Guardian)*	*(Date and Time)*

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)*	REGISTER NO.	WARD NO.

STANDARD FORM 522 (Rev. 10-76)
General Services Administration &
Interagency Comm. on Medical Records
FPMR 101-11.806-8
522-109

NSN 7540-00-634-4165

Standard Form 66 D
April 1985
U.S. Office of Personnel Management
FPM Supplement 293-31
66-501

EMPLOYEE MEDICAL FOLDER

CAUTION
MEDICAL RECORD—RESTRICTED USAGE

1. Your use of the contents of this folder must be in accordance with the instructions in The Guide to Personnel Record Keeping.
2. You must safeguard this folder and its contents while it is in your possession.
3. You are required to keep this folder in a locked place when it is not in use.
4. You are normally prohibited from disclosing the contents of this folder to anyone; exceptions are those officials of your agency demonstrating an official need for the record and those other disclosures permitted by the Privacy Act of 1974 (5 U.S.C. 552a).
5. After use, promptly return this folder to the employee responsible for its filing.
6. Willful violations of these requirements are subject to criminal penalties (5 U.S.C. 552a(i)).

Place label between lines.
Type information on label as shown.

Name (Last, First, M.I.) DOB:
SSN:

NSN 7540-01-209-4939
For Label Use:
NSN 7530-00-577-4376 (cut sheet) or
NSN 7530-00-082-2661 (marginally punched)

GPO : 1985 O 460-498 (22)

INPATIENT MEDICAL RECORD COVER SHEET
(See Privacy Act Statement on Reverse)

Name: _____ SSN: _____ Rank/Rate: _____
Last, First, MI

Unit: _____

Date of Birth: ___/___/____ Religon: _____
YY MM DD

Home Address: _____

Next of Kin: _____ Relationship: _____

Address: _____ Phone #: _____

_____ _____

Previous Admission: ☐ Yes ☐ No If yes, Date: ___/___/____
YY MM DD

Date of Present Admission: ___/___/____ Time: _____ Hours
YY MM DD

Provisional Diagnosis	Provisional Diagnosis
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____

Date of Discharge: ___/___/____ Time: _____ Hours
YY MM DD

DISPOSITION

Duty Status: ☐ FFD ☐ NFFD ☐ FFLD Restrictions: _____

_____

Activity Restrictions: _____

Diet: _____

Medications: _____

Follow-up Appointment(s): _____

_____ _____
Admitting Medical Officer **Discharging Medical Officer**

Time Unit Notified: ___/___/____ Time: _____ Hours
YY MM DD

Name of Staff Member Notifying: _____

Name of Person at Unit Receiving Call: _____
Name and Rank/Rate

PRIVACY ACT STATEMENT

In accordance with 5 USC 552a (e)(3), the following applies to persons providing personal information to the U.S. Coast Guard.

1. Section 632, Title 14 USC, § 1071 – 1087. Title 10 USC, and Executive Order 9397 authorizes collection and application of this information.

2. The principal purpose for which this information is intended is to assist medical personnel in developing records to facilitate and document your health condition(s), in order to provide a complete account of care rendered, including diagnosis, treatment, and results. The social security number is necessary to identify the person and records. Family information is required for notification of next of kin in the unlikely event of an emergency.

3. The routine use of this information is for review by attending medical officers and for future reference in rendering health care.

4. Disclosure of this information is voluntary. However, failure to provide the requested information may result in an inability of the Coast Guard medical personnel to deliver comprehensive treatmen.

Please note the following and indicate your wishes:

I DO / DO NOT GIVE PERMISSION FOR THE ATTENDING MEDICAL OFFICER AND THE DISPENSARY STAFF TO DISCUSS MY MEDICAL CONDITION OR THE SITUATION OF MY ADMISSION WITH MY PARENTS OR LEGAL GUARDIANS, UPON MY REQUEST.

_____ _____

Signature Date

_____

Witness

— —

PERSONNEL AUTHORIZED SEPARATE RATIONS

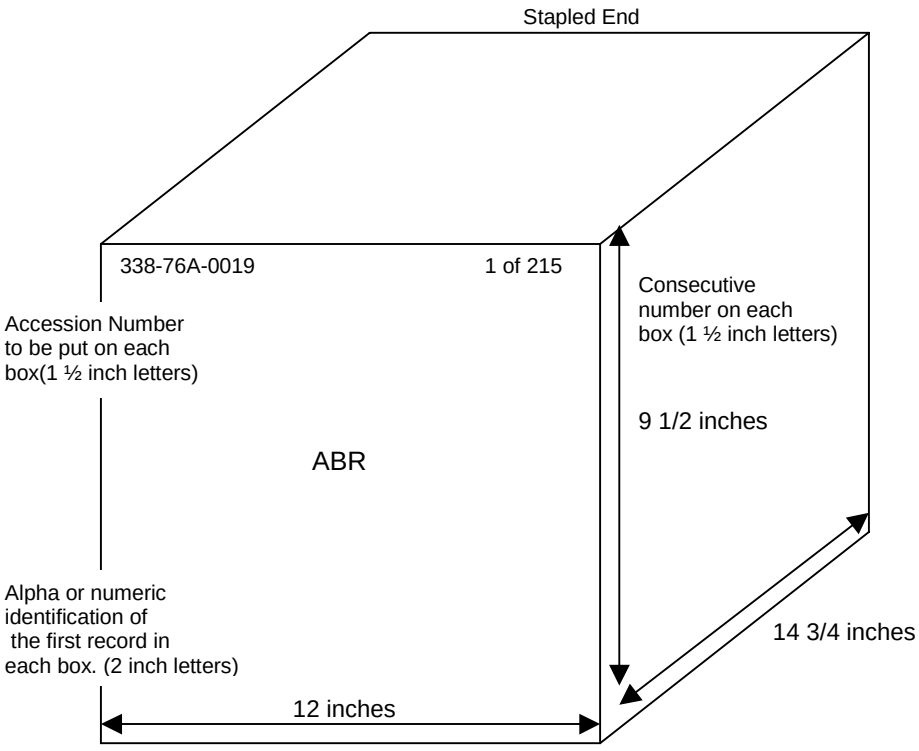
I understand that this facility provides three meals daily for all patients. Further, persons authorized to mess separately will be required to make repayments for meals consumed during their stay.

I have read and understand the statement about separate rations.

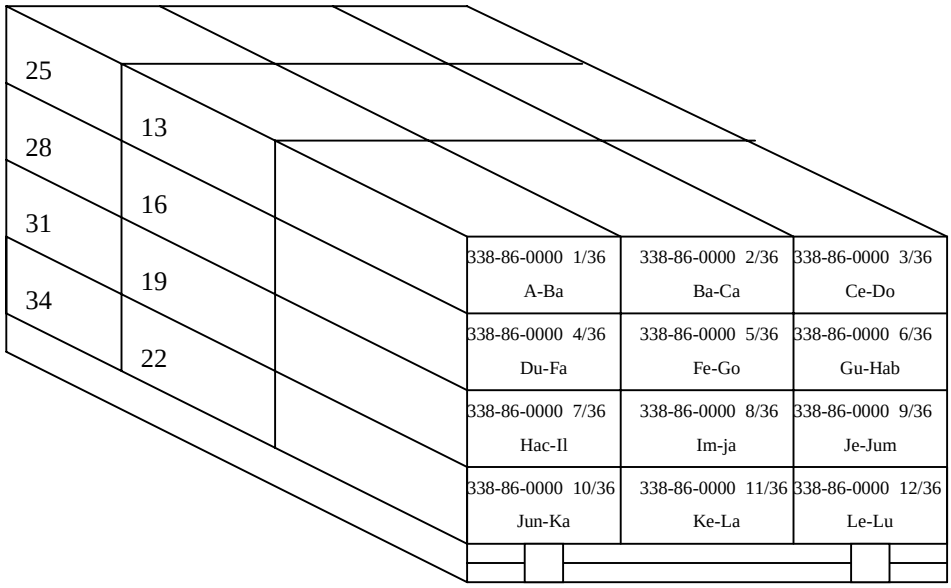
_____ _____

Signature Date

BACK


Stapled End
338-76A-0019
1 of 215
Consecutive number on each box (1 ½ inch letters)
Accession Number to be put on each box(1 ½ inch letters)
9 1/2 inches
ABR
Alpha or numeric identification of the first record in each box. (2 inch letters)
14 3/4 inches
12 inches

BACK


25
28
31
34
13
16
19
22
338-86-0000 1/36
A-Ba
338-86-0000 2/36
Ba-Ca
338-86-0000 3/36
Ce-Do
338-86-0000 4/36
Du-Fa
338-86-0000 5/36
Fe-Go
338-86-0000 6/36
Gu-Hab
338-86-0000 7/36
Hac-Il
338-86-0000 8/36
Im-ja
338-86-0000 9/36
Je-Jum
338-86-0000 10/36
Jun-Ka
338-86-0000 11/36
Ke-La
338-86-0000 12/36
Le-Lu

INSTRUCTIONS

NURSE: Retain a copy and send to Pharmacy after each order is written.

MEDICAL RECORD | **DOCTOR'S ORDERS** *(Sign all orders)*

HOUR START	HOUR STOP	RX	DRUG ORDERS	DOCTOR'S SIGNATURE	NURSE'S SIGNATURE

If needed, continue on Page 2.

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name – last, first, middle; grade; rank; rate; hospital or medical facility)*

REGISTER NO. | WARD NO.

DOCTOR'S ORDERS

STANDARD FORM 508 (Rev. 10-7
Prescribed by GSA and ICMR
FPMR 101-11 806-8
508-110

Standard Form 506 (Rev 2-99) AUTHORIZED FOR LOCAL REPRODUCTION

Clinical Record		PHYSICAL EXAMINATION					
Date of Exam	Height	Weight			Temperature	Pulse	Blood Pressure
		Average	Maximum	Present			

Instructions: Describe (1) General Appearance and Mental Status; (2) Head and Neck (General); (3) Eyes; (4) Ears; (5) Nose; (6) Mouth; (7) Throat; (8) Teeth; (9) Chest (General); (10) Breast; (11) Lungs; (12) Cardiovascular; (13) Abdomen; (14) Hernia; (15) Genitalia; (16) Pelvic; (17) Rectal; (18) Prostate; (19) Back; (20) Extremities; (21) Neurological; (22) Skin; (23) Lymphatics.

(Continue reveres side)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	First	MI	
DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT		
PATIENT'S IDENTIFICATION (For typed or written entries give: Name-Last First, Middle; grade; date; hospital or medical facility)			REGISTER NO	WARD NO

PHYSICAL EXAMINATION RECORD
Standard Form 506 (Rev 2-99)
Prescribed by GSA/ICMR (41 CFR) 101-11 .203(b)(10)

SF 506 (Rev 2-99)

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

PHYSICAL EXAMINATION

INITIAL IMPRESSION

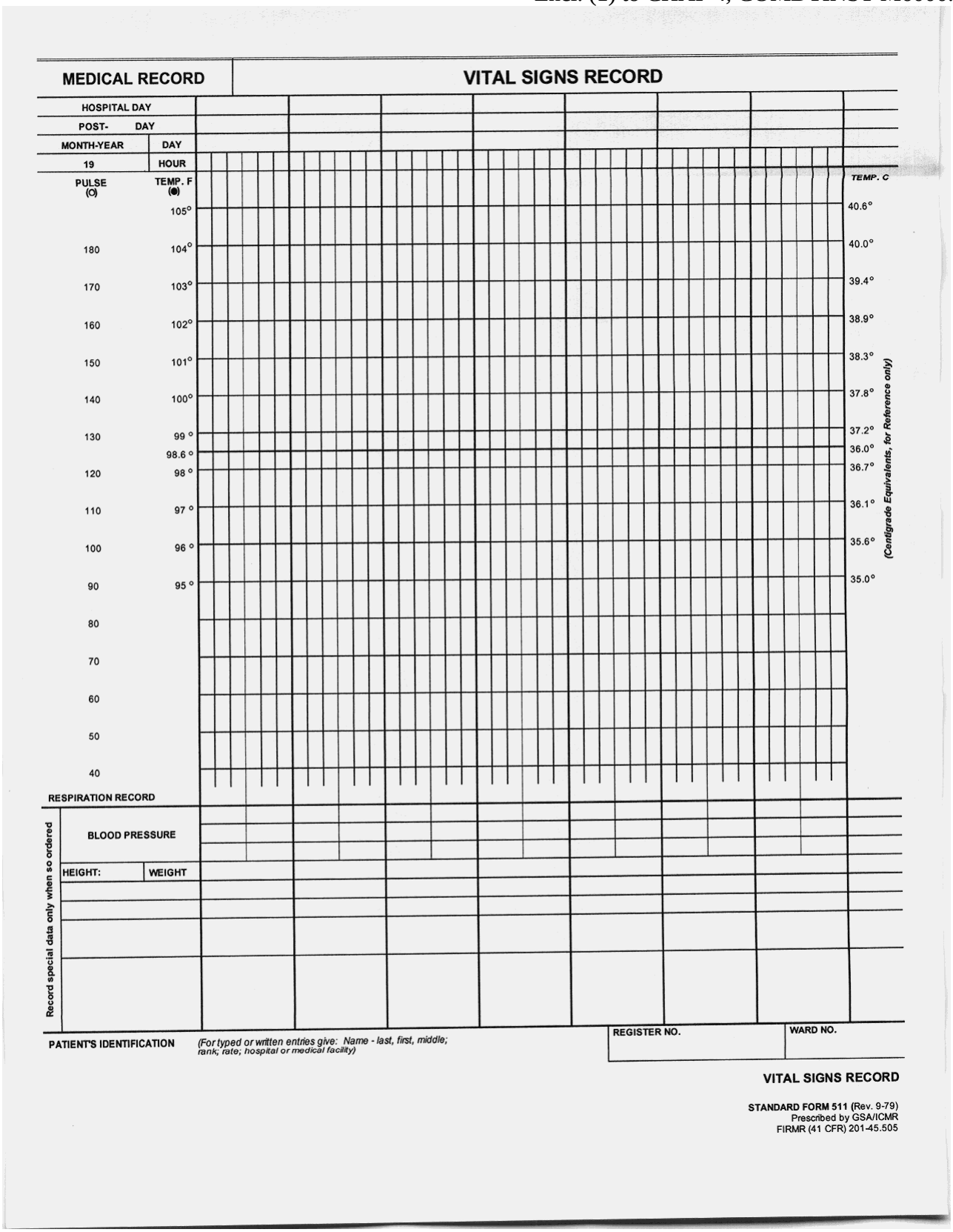
SIGNATURE OF PHYSICIAN	NAME OF PHYSICIAN

Standard Form 506 (Rev. 2-99) BACK

MEDICAL RECORD	PROGRESS NOTES
DATE	
	(Continue on reverse side)

PATIENT'S IDENTIFICATION *(For typed or written entries give: name – last, first, middle; grade; rank; rate; hospital or medical facility)*	REGISTER NO.	WARD NO.

PROGRESS NOTES
MEDICAL RECORD
STANDARD FORM 509 (REV-7-91) EG
Prescribed by GSA/ICMR (41 CFR) 201-9.202-1
Designed using Perform Pro. WHS/DIOR, Jul94



MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR | DAY

19 | HOUR

PULSE (O) | TEMP. F (●)

105° | 104° | 103° | 102° | 101° | 100° | 99 ° | 98.6 ° | 98 ° | 97 ° | 96 ° | 95 °

180 | 170 | 160 | 150 | 140 | 130 | 120 | 110 | 100 | 90 | 80 | 70 | 60 | 50 | 40

TEMP. C

40.6° | 40.0° | 39.4° | 38.9° | 38.3° | 37.8° | 37.2° | 36.0° | 36.7° | 36.1° | 35.6° | 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

HEIGHT: | WEIGHT

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; rank; rate; hospital or medical facility)

REGISTER NO. | WARD NO.

VITAL SIGNS RECORD

STANDARD FORM 511 (Rev. 9-79)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-45.505

ABBREVIATED MEDICAL RECORD	1. ADMISSION DATE*(yyyymmdd)*
2. CHIEF COMPLAINT, PERTINENT HISTORY, AND PERTINENT SYSTEM REVIEW	
3. PHYSICAL EXAMINATION *(Including pertinent positives and negatives)*	
4. IMPRESSION *(enter admission note with plan on progress notes)*	
5. ADMITTING OFFICER	
a. SIGNATURE	b. DATE SIGNED *(YYYYMMDD)*
6. DISCHARGE NOTE *(Brief hospital course, diagnoses, procedures, condition on discharge, pertinent discharge information (including medications, diet, activity limitations, follow-up instructions).)*	7. DISCHARGE DATE *(YYYYMMDD)*

8. DISCHARGE OFFICER			
a. NAME *(Last, First, Middle Initial*	b. GRADE	c. TITLE	d. SIGNATURE
9. PATIENT IDENTIFICATION *(For typed or written entries: Name (last, first, middle), grade, SSN, date of birth, hospital or medical facility, ward number, and register number)*			10. OUTPATIENT/HEALTH RECORD MAINTAINED AT: 11. COPY PLACED IN OUTPATIENT RECORD (x WHEN DONE)

DD FORM 2770, APR 1998 (EG*) Replaces SF 509*